



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

ORTHOTEXAS PHYSICIANS AND SURGEONS  
4780 N JOSEY LANE  
CARROLLTON TX 75010

#### **Respondent Name**

TRAVELERS INDEMNITY CO

#### **Carrier's Austin Representative Box**

Box Number 05

#### **MFDR Tracking Number**

M4-12-1327-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary as Listed on the Table of Disputed Services:** "denied for timely filing-we file electronically and submitted proof from our Clearinghouse that the insurance received this claim in a timely manner"

**Amount in Dispute:** \$95.92

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The Provider performed the services and submitted billing to their electronic billing partner, Realmid. The billing was ultimately received by the Carrier and denied based on the failure to timely submit the billing...The Carrier maintains the denial on the basis that the billing was not timely submitted... The Carrier contends the Provider is not entitled to additional reimbursement."

**Response Submitted by:** Travelers, 1501 S. Mopac Expressway, Suite A-320, Austin, Texas 78746

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 18, 2011	CPT Code 99213	\$95.92	\$95.92

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers'

compensation medical bills for reimbursement.

3. 28 Texas Administrative Code §102.4 sets out the rules for Non-Commission Communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement of professional medical services provided on or after March 1, 2008.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated July 6, 2011

- TXH3- 29 – THE TIME LIMIT FOR FILING HAS EXPIRED. PER TEXAS LABOR CODE 480.027, BILLS MUST BE SENT TO THE CARRIER ON A TIMELY BASIS, WITHIN 95 DAYS FROM DATES OF SERVICE.

Explanation of benefits dated November 10, 2011

- W4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.

### **Issues**

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with Texas Labor Code, Section §408.027 and 28 Texas Administrative Code §102.4?
3. Is the requestor entitled to reimbursement?

### **Findings**

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, “a health care provider shall not submit a medical bill later than the 95<sup>th</sup> day after the date the services are provided.” No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.
2. Texas Labor Code §408.027(a) states, in pertinent part, that “Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment.” 28 Texas Administrative Code §102.4(h) states that “Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.” Review of the submitted information finds that the requestor has supported that the provider, filed for reimbursement within 95 days after the date of service. The submitted documentation supports that the payer was the correct insurance carrier, Travelers. Per 28 Texas Administrative Code §102.4(h), documentation submitted by the requestor in this medical fee dispute sufficiently supports that a medical bill was submitted for payment to the insurance carrier within 95 days after the date on which the health care services were provided to the injured employee.
3. Review of the submitted documentation finds that the requestor in this medical fee dispute has timely filed the medical bills with the insurance carrier in accordance with Texas Labor Code §408.027. This respondent's denial reason is not supported. The disputed services will therefore be reviewed per the applicable Division rules and fee guidelines. Per 28 Texas Administrative Code §134.203, the calculations for CPT code 99213 is as follows:

\$54.54 WC CF/33.9764 Medicare CF x \$66.90 Participating Amount = \$107.39

The total MAR for CPT code 99213 billed on February 18, 2011 is \$107.39. The requestor is seeking \$95.92, therefore, this amount is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$95.92.

## **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$95.92 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

_____ Signature	_____ Medical Fee Dispute Resolution Officer	February 7, 2012 Date
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### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**